

(iii) For year 2 of implementation, using the NIS database in accordance with §1187.91(1)(ii), the Department will calculate the two year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility. Using the NIS database in accordance with §1187.91(1)(iii), subparagraph (iv) applies.

(iv) For year 3 of implementation and thereafter, the Department will calculate the three year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

(2) The average administrative cost per diem for each nursing facility will be arrayed within the respective peer groups and a median price determined for each peer group.

(3) The median of each peer group will be multiplied by 1.04, and the resultant peer group price will be assigned to each nursing facility in the peer group to determine the nursing facility's administrative rate.

(d) Using the appraisal data in accordance with §1187.91, the Department will set rates for the capital cost category as follows:

(1) For each nursing facility, the appraised depreciated replacement value of the nursing facility, adjusted for the per bed limitation in accordance with §1187.112 (relating to cost per bed limitation adjustment) and the bed moratorium addressed in §1187.113 (relating to capital component payment limitation), will be added to the appraised depreciated replacement value of the movable equipment, adjusted for the bed moratorium, to derive the total appraised value.

(2) The total appraised value will be multiplied by the financial yield rate to determine the fair rental value for each nursing facility.

(3) The cost of real estate taxes or reasonable payment made in lieu of real estate taxes will be added to the fair rental value for each nursing facility to derive the capital cost.

(4) For each nursing facility, the nursing facility capital cost, as adjusted, will be divided by the total actual resident days, adjusted to 90% occupancy, if applicable, to derive the capital rate for the nursing facility.

(e) The nursing facility per diem rate will be computed by adding the resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

§1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities.

The Department will establish rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities, and former prospective payment nursing facilities as follows:

(1) New nursing facilities.

(i) The net operating portion of the case-mix rate is determined as follows:

(A) A new nursing facility will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under §1187.33 (relating to resident data reporting requirements) is used in a rate determination under §1187.96(a)(4) (relating to price and rate setting computations).

(B) The nursing facility will be assigned to the appropriate peer group. The peer group price for resident care, other resident related and administrative costs will be assigned to the nursing facility until there is at least one audited nursing facility cost report used in the rebasing process.

(ii) The capital portion of the per diem rate will be calculated based on the appraisal of the nursing facility and the cost of real estate taxes or reasonable payment made in lieu of real estate taxes under §1187.96(d)(3).

(iii) Newly constructed nursing facilities are exempt from the adjustment to 90% occupancy until the nursing facility has participated in the MA Program for one full annual price setting period as described in §1187.95 (relating to general principles for rate and price setting).

(2) Nursing facilities with a change of ownership and reorganized nursing facilities.

(i) The new nursing facility provider will be paid exactly as the old nursing facility provider. Net operating and capital rates for the old nursing facility provider will be assigned to the new nursing facility provider.

(ii) Resident assessment data will be transferred from the old nursing facility provider number to the new nursing facility provider number. The old nursing facility's MA CMI will be transferred to the new nursing facility provider.

(3) Former prospective payment nursing facilities. A nursing facility that received a prospective rate prior to the implementation of the case-mix payment system will be treated as a new nursing facility under paragraph (1) for the purpose of establishing a per diem rate.

SUBCHAPTER H. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§1187.101. General payment policy.

(a) Payment for nursing facility services will be subject to the following conditions and limitations:

- (1) This chapter and Chapter 1101 (relating to general provisions).
- (2) Applicable State statutes.
- (3) Applicable Federal statutes and regulations and the Commonwealth's approved State Plan.

(b) Payment will not be made for nursing facility services at the MA per diem rate if full payment is available from another public agency, another insurance or health program or the resident's resources.

(c) Payment will not be made in whole or in part for nursing facility services provided during a period in which the nursing facility's participation in the MA Program is terminated.

(d) Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101. In addition, the Department will perform the reviews specified in this chapter for controlling the utilization of nursing facility services.

§1187.102. Utilizing Medicare as a resource.

(a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified nursing facility and is authorized by the Medicare Program to receive nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the nursing facility's MA per diem rate for nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the nursing facility. The Department will not pay more than the maximum coinsurance amount.

(b) If a resident has Medicare Part B coverage, the nursing facility shall use available Medicare Part B resources for Medicare Part B services before payment is made by the MA Program.

(c) The nursing facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible resident because of the limit of the nursing facility's MA per diem rate.

(d) The Department will recognize the Medicare payment as payment in full for each day that a Medicare payment is made during the Medicare-only benefit period.

(e) The cost of providing Medicare Part B type services to MA recipients not eligible for Medicare Part B services which are otherwise allowable costs under this part are reported in accordance with §1187.72 (relating to cost reporting for Medicare Part B type services).

§1187.103. Cost finding and allocation of costs.

(a) A nursing facility shall use the direct allocation method of cost finding. The costs will be apportioned directly to the nursing facility and residential or other facility, based on appropriate financial and statistical data.

(b) Allowable operating cost for general nursing facilities and county nursing facilities will be determined subject to this chapter and Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, except that if this chapter and the HCFA Pub. 15-1 differ, this chapter applies.

§1187.104. Limitations on payment for reserved beds.

The Department will make payment to a nursing facility for a reserved bed when the resident is absent from the nursing facility for a continuous 24-hour period because of hospitalization or therapeutic leave. A nursing facility shall record each reserved bed for therapeutic leave on the nursing facility's daily census record and MA invoice. When the bed reserved for a resident who is hospitalized is temporarily occupied by another resident, a nursing facility shall record the occupied bed on the nursing facility's daily MA census record and the MA invoice. During the reserved bed period the same bed shall be available for the resident upon the resident's return to the nursing facility. The following limits on payment for reserved bed days apply:

(1) *Hospitalization.*

(i) A resident receiving nursing facility services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will pay a nursing facility at a rate of one-third of the nursing facility's current per diem rate on file with the Department for a hospital reserved bed day.

(ii) If the resident's hospital stay exceeds the Department's 15 reserved bed days payment limitation, the nursing facility shall readmit the resident to the nursing facility upon the first availability of a bed in the nursing facility if, at the time of readmission, the resident requires the services provided by the nursing facility.

(iii) Hospital reserved bed days may not be billed as therapeutic leave days.

(2) *Therapeutic leave.* A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the nursing facility if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a nursing facility the nursing facility's current per diem rate on file with the Department for a therapeutic leave day.

§1187.105. Limitations on payment for prescription drugs.

The Department's per diem rate for nursing facility services does not include prescription drugs. Prescribed drugs for the categorically needy and medically needy are reimbursable directly to a licensed pharmacy in accordance with Chapter 1121 (relating to pharmaceutical services).

§1187.106. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents is certifiable and licensed to

provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring nursing facility provider number as long as the transferring nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§1187.107. Limitations on resident care and other resident related cost centers.

(a) The Department will set a limit on the resident care peer group price for each nursing facility for each year, using the NIS database as specified in §1187.91 (relating to database), to the lower of:

- (1) The nursing facility resident care peer group price.
- (2) One hundred three percent of the nursing facility's average case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility resident care peer group price.

(b) The Department will set a limit on the other resident related peer group price for each nursing facility for each base year, using the NIS database as specified in §1187.91 to the lower of:

- (1) The nursing facility other resident related peer group price.
- (2) One hundred three percent of the nursing facility average other resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility other resident related peer group price.

§1187.108. Gross adjustments to nursing facility payments.

(a) The case-mix payment system is a prospective system. There is no cost settlement under the case-mix payment system.

(b) Certain adjustments may be made which increase or decrease the payment which a nursing facility may have otherwise received. Gross adjustments to nursing facility payments are based on one or more of the following general provisions:

(1) If audit findings result in changing the peer group median and the peer group price, a retrospective gross adjustment is made for each nursing facility in the peer group where the change occurred.

(2) If a nursing facility's MA CMI changes as a result of UMR resident assessment audit adjustments, retrospective gross adjustments shall be made for the nursing facility involved.

(c) Specific adjustments of the gross payments received by a nursing facility may be required by §§1187.109 - 1187.115.

§1187.109. Medicare upper limit on payment.

Nursing facilities shall submit Medicare information on the MA-11. MA payments will not exceed in the aggregate the comparable amount that Medicare would have paid had the Medicare Program reimbursed for the services rendered.

§1187.110. Private pay rate adjustment.

The MA rate is limited by the nursing facility's private pay rate for the comparable rate period.

§1187.111. Disproportionate share incentive payments.

(a) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(1) The nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(2) The nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(b) The disproportionate share incentive payments will be based on the following for year one of implementation:

	<u>Overall Occupancy</u>	<u>MA Occupancy (y)</u>	<u>Per Diem Incentive</u>
Group A	90%	$\geq 90\% \text{ y}$	\$2.50
Group B	90%	$88\% \leq y < 90\%$	\$1.70
Group C	90%	$86\% \leq y < 88\%$	\$1.00
Group D	90%	$84\% \leq y < 86\%$	\$0.60
Group E	90%	$82\% \leq y < 84\%$	\$0.30
Group F	90%	$80\% \leq y < 82\%$	\$0.20

(c) For each year subsequent to year 1 of implementation, disproportionate share incentive payments as described in subsection (b) will be inflated forward using the Health Care Financing Administration Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(d) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that in no case will payment be made before 210 days of the close of the nursing facility fiscal year.

(e) For year 1 of implementation only, facilities with a June 30 cost report year end will receive a disproportionate share payment based on the January 1 through June 30 time period.

§1187.112. Cost per bed limitation adjustment.

(a) For year one of implementation the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of \$22,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable equipment will not be included in the \$22,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the \$22,000 per bed limitation will be made. The full appraisal value will not be recognized.

(b) For year two of implementation and year three of implementation and thereafter the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of \$26,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable equipment will not be included in the \$26,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the \$26,000 per bed limitation will be made. The full appraisal value will not be recognized.

§1187.113. Capital component payment limitation.

(a) *Conditions.* The capital component payment is subject to the following conditions:

(1) The Department will make the capital component payment on new or additional beds only if one of the following applies:

(i) The nursing facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health by August 31, 1982.

(ii) The nursing facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility located within the county.

(2) The Department will not make the capital component payment unless the nursing facility substantially implements the project under 28 Pa. Code Chapter 401 within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) The capital component payment for replacement beds is allowed only if the nursing facility was issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.

(4) The Department will not make the capital component payment unless written approval was received from the Department prior to the construction of the new beds.